REPORT OF EMPLOYEE INJURY

County of Knox

EMPLOYEE PORTION:

FILL OUT THIS REPORT COMPLETELY AND SUBMIT IT TO YOUR SUPERVISOR WITHIN 24 HOURS OF RECEIVING THE INJURY.

Employee Name:	Employee Mailing Address:			Employee contact number(s): Home Phone: Cell Phone if Different:
Date of Injury:	Time of Injury:	Day of Injury: ☐ Mon. ☐ Wed. ☐ Fri. ☐ Tues. ☐ Thurs. ☐ Sat. ☐ Sun.	Date Reported:	Supervisor reported to (Name and Title):

Shifts You Work:		From: To:			From: To:
	☐ Monday		☐ Friday		
	☐ Tuesday		☐ Saturday		
	☐ Wednesday		☐ Sunday		
	☐ Thursday				

Witness 1 (Name and Title):	Work Phone:
Witness 2 (Name and Title):	Work Phone:

Do you work for another Employer? ☐ Yes ☐ No If Yes, name of employer:	Date & Time you returned to work (if applicable):	Location/Address of Accident:
Object, substance, or exposure which directly brought about your injury:		
Describe your (check one) ☐ Injury ☐ Disease in detail which brought about your injury:		

Doctor(s): Name: Address:	Hospital(s): Name: Address:

SUPERVISOR PORTION:

CHECK THIS REPORT FOR COMPLETENESS AND SUBMIT IT TO YOUR DEPARTMENT MANAGER ASAP

Did injury cause loss Of time (other than On day of injury)? ☐ Yes ☐ No	If yes, date last worked:	Time lost from work on day of injury: hrs.	Will this injury restrict employee's normal job duties? ☐ Yes ☐ No	If restricted, for approximately how many days?	

(Continued on the next page)

A. DESCRIPTION (if different, or if you have more information, than what's in the narrative by the employee above) OF INJURY/ILLNESS ~ BODY PART AFFECTED ~ TREATMENT:

Employee _____ Date _____

Immediate Supervisor _____ Date _____

Department Manager _____ Date _____

Supervisor Accident/Incident Analysis has been completed, reviewed and is attached? ☐ Yes ☐ No

DEPARTMENT MANAGERS – TURN THIS FORM INTO THE COUNTY ADMINISTRATOR WITHIN 24 HOURS FROM WHEN THE INJURY IS REPORTED TO YOU